TruCare Medical Center – Tel: (702) 657-6365

REGISTRATION FORM

(Please Print)

Today's date:	Tel:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms. ❑ Rev.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

Bldg/Apt #:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE AND OTHER INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No	SS#:

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please indicate primary insurance	❑ Medicare Part B	❑ Medicaid (SAMI)	❑ Amerigroup	❑ HPN HMO (Smart Choice)	❑ HPN PPO
❑ Culinary	❑ TriCare/Champus	❑ BC/BS PPO/HMO	❑	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Can we contact you by text?	❑ Yes ❑ No
Can we leave voicemails on given cell no?	❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TruCare Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Proprietary-Designed by AAQ